Malachi's House of Hope

FAMILY SUPPORT REQUEST

contact@malachishouseofhope.org | 248-266-1150

Mail: 9864 E Grand River, Ste. 110-162, Brighton, MI 48116

Please share only what we need to understand your request. Complete digitally or print and write. Fields marked * help us review your request; other fields are optional.

1 Your contact information

Your name *

Relationship to child *

Phone

Email

Provide at least one contact method above. *

Preferred contact: ☐ Call ☐ Text ☐ Email

☐ OK to leave a voicemail ☐ OK to text about this request

Contact instructions / best time to reach you

Street address *

Apartment / unit

City *

State *

ZIP code *

Preferred language / interpreter or accessibility needs

2 Your child and current needs

Child first name or initials *

Age or expected birth month/year *

Condition or diagnosis, if known (brief description only)

Hospital / clinic, if relevant to your request

What support are you requesting? Check all that apply. *

☐ Lodging assistance ☐ Transportation ☐ Meals / groceries

☐ Care items / essentials ☐ Resource connections ☐ Other

When is help needed? *

Estimated amount, if known ($)

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REQUEST DETAILS & CONSENT

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Do not attach medical records or include Social Security, bank, insurance or card numbers.

3 Tell us what would help

Briefly describe your request and how it relates to your child's care. *

If relevant: travel destination, lodging dates, number of people, or other details

All GoFundMe / other fundraisers for this care: links, raised, available (or None) *

Social worker name *

Hospital / organization *

Social worker phone *

Social worker email *

Social worker signature * (sign after printing)

Date *

4 What to know before you submit

Purpose and privacy: MHHO uses this information to review requests, contact families, coordinate support, and maintain service records. Access is limited to personnel who need it for this work. Publicity requires separate permission.

Sharing: This form does not authorize hospital record requests or outside sharing. MHHO will seek specific permission to share information with a hospital, vendor or partner, except where disclosure is required by law.

Availability: A request does not guarantee assistance or payment. Decisions depend on review and available resources. MHHO may request relevant follow-up information.

Contact and records: Consent covers this request, not newsletters or fundraising. Contact MHHO to ask questions, correct information or withdraw your request. Withdrawal may limit coordination; records may be retained where needed or required.

MHHO is not an emergency, medical, or mental health treatment service. For a medical emergency, call 911. For medical questions, contact your child's care team.

Return pages 1-2 by mail, or call MHHO to arrange another return method.

☐ I have read this notice and agree that MHHO may review my request and contact me.

☐ The information is accurate to the best of my knowledge, and I may make this request.

Parent / guardian / adult applicant signature * (sign after printing)

Date *

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OPTIONAL PHOTO, VIDEO & STORY RELEASE

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Your choice is voluntary. You may decline or leave this page blank. Your decision will not affect eligibility for assistance.

Name of person covered (one person per release)

Adult participant or parent / legal guardian name

Relationship / legal authority

1 Choose whether to participate

☐ I DO NOT give permission for publicity. No further selections are needed.

☐ I give permission ONLY for the selections and material identified below.

Materials allowed (check all that apply):

☐ Photographs ☐ Video / voice recordings ☐ Written story / quote

Identify the photo, recording, story, event or date covered by this release

Where MHHO may use this material (check all that apply):

☐ MHHO website / social media ☐ Print / email / educational materials

☐ MHHO events / fundraising campaigns ☐ News / press materials provided by MHHO

Identification (choose one):

☐ No name ☐ First name only

No diagnosis or medical details may be published unless described and approved below.

Approved story / health details and any restrictions (blank = no health details authorized)

2 Permission terms and signature

MHHO may use the selected material for awareness, education and fundraising, without payment. Basic cropping or editing may not change its meaning. Permission lasts two years from signature, or until a minor turns 18, whichever comes first. Adults shown must sign their own release.

To stop future use, email contact@malachishouseofhope.org or write to the mailing address at the top of this page. Withdrawal does not undo uses already made. MHHO will stop new use and remove material it controls where reasonably possible; printed copies and third-party reposts may remain public. Public material may be copied or shared by others.

Adult participant / parent or legal guardian signature

Date